

Dr McCormack and Partners

Quality Report

St Mary's Surgery
37 St Mary's Street,
Ely.
Cambridge
CB7 4HF
Tel: 01353 665511
Website: www.stmarysely.nhs.uk

Date of inspection visit: 16 July 2015
Date of publication: 17/09/2015

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service		Good	
Are services safe?		Good	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive to people's needs?		Good	
Are services well-led?		Good	

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	9
Areas for improvement	9
Outstanding practice	9

Detailed findings from this inspection

Our inspection team	11
Background to Dr McCormack and Partners	11
Why we carried out this inspection	11
How we carried out this inspection	11
Detailed findings	13

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St Mary's Surgery on 16 July 2015. Overall the practice is rated as good.

We found the practice to be safe, effective, caring, responsive to people's needs and well-led. The quality of care experienced by older people, by people with long term conditions and by families, children and young people was good. Working age people, those in vulnerable circumstances and people experiencing poor mental health also received good quality care.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed. Patients' needs were assessed and care was planned and delivered following best practice guidance.

- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Patients said they were treated as individuals and that they were involved in their care and decisions about their treatment. Patients described the practice as caring, helpful and friendly.
- Patients could speak on the telephone and make an appointment with a named GP. Routine as well as urgent appointments were available on the same day.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice valued the importance of quality, improvement and learning and were actively involved in clinicians' education and training and in primary care research.
- There was a clear leadership structure and staff felt supported by management. The practice worked

Summary of findings

closely with its patient participation group and proactively sought feedback from staff and patients. They listened to what patients told them and made improvements accordingly.

We saw areas of outstanding practice:

- The practice provided International Normalized Ratio or INR blood monitoring (a blood test to review and monitor the effectiveness of long term blood thinning medication), for their patients as evening appointments, as a domiciliary service for housebound patients and from a local supermarket.
- The practice was committed to primary care development and education. They took an active part in clinicians' education and primary care research and encouraged staff at all levels to develop their knowledge and skills.

- GPs provided 24 hour cover, seven days a week, to an inpatient rehabilitation ward at a local hospital and often provided patients on end of life care personal 24 hour and weekend contact information to ensure continuity of care.
- Practice information was available in a number of languages both on the practice website and within the practice. The practice also provided sign language support for patients with reduced hearing and large font for both practice information and the website for patients with limited visibility.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should;

- Improve the arrangements for the security of blank prescription forms.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. The practice used every opportunity to learn from internal and external incidents to help them improve. Information about safety was highly valued and was used to promote learning and improvement. Risks to patients and within the practice were assessed and well managed. There were enough staff to keep people safe. Information about safety was recorded, monitored, appropriately reviewed and addressed. Arrangements for the management of medicines were clear and overseen by a dispensary manager.

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at, or above average for the locality. Guidance and standards issued by the National Institute for Health and Care Excellence (NICE) and other bodies was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current standards and legislation. This included assessment of people's capacity, the promotion of good health and the prevention of ill-health. The practice used clinical audit to monitor the effectiveness of the care and treatment they provided and was a host practice as part of an NHS primary care research initiative.

Staff were properly qualified and trained appropriately for their roles and further training needs were identified and planned. The practice carried out appraisals of staff to ensure they were competent and had opportunities for development. Effective multidisciplinary working arrangements were in place.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Patients told us clinicians gave them the time and attention they needed and several referred to specific members of staff for the care and treatment they had received. We were told they felt well supported over the years or during extended periods of treatment. Patients used words such as exceptional, excellent, caring and dignified to describe their care and treatment. Information for patients about the services available was easy to

Good



Summary of findings

understand and accessible in a number of languages and in larger font for patients with reduced visibility. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice reviewed and understood the needs of their patient population particularly those who were at risk of unplanned hospital admissions. The practice ran a proactive care register for those who were most at risk and provided personalised care plans for this group of patients. Patients reported good access to the practice with urgent appointments available the same day as well as late appointments Monday and Wednesday evenings.

The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service.

Good



Are services well-led?

The practice is rated as good for providing well-led services. The practice had an open and supportive leadership and a clear vision with quality, improvement and learning as its top priorities. The practice promoted high standards and the team took pride in delivering a high quality service to its patients. There was a clear leadership structure and staff felt supported by management. The practice had well organised management systems and met regularly to review the delivery of care and the management of the practice. The practice had systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and responded to suggestions made. The practice had an active patient participation group (PPG). A PPG is made up of a group of patients registered with a practice who work with the practice team to improve services and the quality of care. There was evidence that the practice had a culture of learning, development and improvement including their involvement in education and primary care research. An example of this was that one GP provided clinical supervision and training for the practice nurse whilst on their non-medical prescribing course and prior to them becoming the first nurse practitioner at the practice.

Good



Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The practice is rated as good for the care of older people. It was responsive to their needs. Home visits and priority appointments (including for patients who were receiving palliative care) were available and prescriptions could be delivered to their home address by the practice dispensary. Multi-disciplinary team meetings took place for elderly people with complex needs. External support was signposted and made available for them to access. Elderly patients had a named GP to receive continuity of care. Telephone consultations were available. The practice provides medical services to a high proportion of retired and elderly patients with 24% being over 65 and 10% over 75. The practice did not provide care to any nursing homes, but provided medical support to three local care homes and one boarding school. The GPs also provided 24 hour cover, seven days a week, to an inpatient rehabilitation ward at a local hospital and worked closely with a consultant community geriatrician and their team. The practice also worked with a local multi-disciplinary coordinator to support vulnerable and elderly patients. The practice was pro-active in encouraging patients to receive flu and pneumococcal vaccinations.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The GPs provided 24 hour cover seven days a week to an inpatient rehabilitation ward at a local hospital and worked closely with a consultant community geriatrician and their team. The practice also worked with a local multi-disciplinary coordinator to support vulnerable patients. GPs often provided patients on end of life care personal 24 hour and weekend contact information to ensure continuity of care. The practice provided International Normalized Ratio or INR blood monitoring (a blood test to review and monitor the effectiveness of long term blood thinning medication), for their patients as evening appointments, as a domiciliary service for housebound patients and from a local supermarket. All GPs and

Good



Summary of findings

nurses had undertaken minor illness training and were able to provide treatment and care in this area. GPs often provided patients on end of life care personal 24 hour and weekend contact information to ensure continuity of care.

Families, children and young people

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments with GPs and nurses were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives and community services. Antenatal care was referred in a timely way to external healthcare professionals. Parents we spoke with were positive about the services available to them and their families at the practice. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health. The practice provided medical support to a local boarding school.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the population group of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a wide range of health promotion and screening at the practice which reflected the needs for this age group. The practice provided medical services to a high proportion of retired and elderly patients with 24% being over 65 and 10% over 75. The practice provided International Normalized Ratio or INR blood monitoring (a blood test to review and monitor the effectiveness of long term blood thinning medication), for their patients as evening appointments, as a domiciliary service for housebound patients and from a local supermarket.

Good



People whose circumstances may make them vulnerable

This practice is rated as good for the care of people living in vulnerable circumstances. The practice had a learning disability (LD) register and all patients with learning disabilities were invited to attend for an annual health check. Longer appointments were available for this and the practice used information in suitable

Good



Summary of findings

formats to help them explain information to patients. Staff at the practice worked with other professionals to help ensure people living in difficult circumstances had opportunities to receive the care, support and treatment they needed. The staff team were aware of their responsibilities regarding information sharing and dealing with safeguarding concerns. Practice information was available in a number of languages both on the practice website and within the practice. The practice also provided a hearing loop and sign language support for patients with reduced hearing and large font for both practice information and the website for patients with limited visibility.

A code was added to the computer records of patients with literacy problems to alert staff to their needs, different picture methods of communication were available to aid communication and understanding.

People experiencing poor mental health (including people with dementia)

The practice proactively identified patients who may be at risk of developing dementia. The practice were aware of the number of patients they had registered who were suffering from dementia and additional support was offered. This included those with caring responsibilities. A register of dementia patients was being maintained and their condition regularly reviewed through the use of care plans. Patients were referred to specialists and on-going monitoring of their condition took place when they were discharged back to their GP. Annual health checks took place with extended appointment times if required. Patients were signposted to support organisations such as Improving Access to Psychological Therapies and the community psychiatric nurse for provision of counselling and support. Staff had a clear understanding of the 2005 Mental Capacity Act and their role in implementing the Act.

Good



Summary of findings

What people who use the service say

The practice provided patients with information about the Care Quality Commission prior to the inspection and had displayed our poster in the waiting room.

Our comments box was displayed prominently and comment cards had been made available for patients to share their experience with us. We collected 4 comment cards; all the cards indicated that patients were satisfied with the support, care and treatment they received from the practice. Patients used words such as exceptional, excellent, caring and dignified to describe the care and treatment they received. Comments cards also included positive comments about the services available at the practice, appointment availability, the skills of the staff, the treatment provided by the GPs and nurses, the cleanliness of the practice, the support and helpfulness of the staff and the way staff listened to their needs. These findings were also reflected during our conversations with patients during our inspection.

The feedback from patients we spoke with was extremely positive. Patients told us about the ability to speak or see a GP on the day and where necessary get an appointment when it was convenient for them with the GP of their choice. We were given clear examples of

effective communication between the practice and other services. Patients told us they felt the staff respected their privacy and dignity and the GPs, nursing, reception and the management teams were all very approachable and supportive. We were told they felt confident in their care and liked the continuity of care they received at the practice. The patients we spoke with told us they felt their treatment was professional and effective and they were very happy with the service provided. They told us things were clearly explained to them and clinicians gave them sufficient time during consultations and information to be able to make decisions about their treatment and care without feeling pressured. Patients told us that all the team were very supportive and that they thought the practice was very well run. Patients told us if they needed to complain they would speak to the reception team or the management team. We were told they felt their concerns would be listened to.

Patients told us they were happy with the supply of repeat prescriptions. All the patients we spoke with and the respondents to the latest Friends and Family test told us they would happily recommend the practice and its facilities to other patients.

Areas for improvement

Action the service **SHOULD** take to improve

- Improve the arrangements for the security of blank prescription forms.

Outstanding practice

- The practice provided International Normalized Ratio or INR blood monitoring (a blood test to review and monitor the effectiveness of long term blood thinning medication), for their patients as evening appointments, as a domiciliary service for housebound patients and from a local supermarket.
- The practice was committed to primary care development and education. They took an active part in clinicians' education and primary care research and encouraged staff at all levels to develop their knowledge and skills.
- GPs provided 24 hour cover, seven days a week, to an inpatient rehabilitation ward at a local hospital and often provided patients on end of life care personal 24 hour and weekend contact information to ensure continuity of care.

Summary of findings

- Practice information was available in a number of languages both on the practice website and within the

practice. The practice also provided sign language support for patients with reduced hearing and large font for both practice information and the website for patients with limited visibility.

Dr McCormack and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector, a GP specialist adviser and a practice manager specialist adviser.

Background to Dr McCormack and Partners

Dr McCormack and Partners, also known as St Mary's Surgery, provides general medical services to around 15,771 patients living in Ely, 11 local villages and the surrounding rural area. The premises are purpose built with administration offices situated across the street. Limited parking is available behind the surgery and in local public car parks.

The practice has a team of ten GPs meeting patients' needs. Six GPs are partners, meaning they hold managerial and financial responsibility for the practice, with four GPs providing sessional clinical support. There is a team of 13 nurses including one clinical nurse manager, eight practice nurses and four health care assistants who run a variety of appointments for long term conditions, minor illness and family health.

There is a practice manager, a deputy practice manager, an IT manager, office manager, a dispensary manager, a team of dispensers and a team of non-clinical, administrative, secretarial and reception staff who share a range of roles, some of whom are employed on flexible working arrangements. Community midwives run sessions twice a week at the practice.

The practice provides a range of clinics and services, which are detailed in this report, and operates generally between the hours of 8.20am and 6.00pm, Monday to Friday with additional hours from 6.30pm to 8.00pm on Monday and Wednesday evenings (last appointment at 7.30pm). Appointments times are staggered throughout the day in response to population dynamics. Outside of these hours, primary medical services are accessed through the NHS 111 service.

The practice dispenses to 25% of its registered patients and saw an overall growth in its patient population of 130 in the last quarter. The practice provides medical services to a high proportion of retired and elderly patients with 24% being over 65 and 10% over 75. The practice does not provide care to any nursing homes, but provides medical support to three local care homes and one boarding school. The GPs also provide 24 hour cover seven days a week to an inpatient rehabilitation ward at a local hospital and work closely with a consultant community geriatrician and their team. The practice also works with a local multi-disciplinary coordinator to support vulnerable and elderly patients.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme in accordance with our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. During our inspection we spoke with a range of staff including GP partners, practice nurses, dispensers, health care assistants, reception and administrative staff and the practice manager. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. These were located on the practice electronic system and staff demonstrated how to access them.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked 24 incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of actions taken as a result, for example with an allergy to a prescribed medicine, new cancer diagnosis or the unexpected death of a patient. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken, in line with the practice's policy.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were disseminated to all clinical staff electronically and discussed at meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that staff had received relevant role specific training on safeguarding. We

asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children and were able to describe to us occasions when they had safeguarding concerns about a patient and the actions they had taken. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. The practice had dedicated GPs appointed as leads in safeguarding vulnerable adults and children and they had received the appropriate level of training. In addition one GP lead as the practice dignity champion. Other managerial staff ensured there was always a senior member of staff on duty and available to support staff during surgery opening hours. All staff we spoke with were aware who these leads were and who to speak to both internally and externally if they had a safeguarding concern.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient, including scanned copies of communications from hospitals.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example children subject to child protection plans, patients diagnosed with dementia or those requiring additional support from a carer.

There was a chaperone policy, which was visible on the waiting room noticeboard, in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Nursing and other clinical staff were primarily used as a chaperone. There were designated staff who would act as a chaperone if nursing staff were not available. All staff who undertook chaperoning had received training and spoke knowledgeably about the correct way this should be undertaken. This included where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS)

Are services safe?

checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We looked at all areas where medicines were stored, and spent time in the dispensary observing practices, talking to staff and looking at records. We noted the dispensary itself was well organised and operated with adequate staffing levels.

The dispensary manager told us that members of staff involved in the dispensing process were appropriately qualified and their competence was checked each year. We looked at staff training files for three dispensary staff, we found they all contained evidence of relevant training and all had evidence that an annual assessment of competence was completed. We were satisfied that medicines were dispensed by appropriately qualified and competent staff.

There were arrangements in place for the security of the dispensary so that it was only accessible to authorised staff. The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary. We looked at the annual return of performance against the DSQS standards and were assured that dispensing performance was of a high standard. We saw evidence that the practice monitor and record dispensing errors or near misses. We were assured that there was a culture of learning from medicine related incidents. Dispensary staff carried out reviews of medicines with patients but these were constrained by the lack of a private consultation area.

A policy and procedure folder was available in the dispensary for staff to refer to about standard operating practices. We saw that procedures were updated regularly, and records showed that staff had read the procedures relevant to their work.

Patients were offered a choice of methods for requesting repeat prescriptions. We saw that this process was handled well by dispensary staff to ensure patients were not kept waiting unduly for their medicines. A medicines delivery service was available for patients in rural settings who may

have difficulty accessing the surgery for their medicines. Arrangements for the tracking of the collection of completed prescriptions, which had been delivered local stores, had been improved since our last inspection.

We found that there were arrangements for the storage of blank prescription forms. These arrangements were not in line with national guidance. However the way these were tracked meant we were assured that if prescriptions were lost or stolen, they could be promptly identified and investigated. We also found that some medicines held in doctor's bags were not stored in the dispensary in line with legal requirements. We told the dispensary manager about this and it was resolved immediately.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example for spillages of bodily fluids. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw the next training had been scheduled for September 2015. We saw evidence that the lead had carried out an audit in October 2014. Where areas for improvement had been identified there was plan to ensure completion of the action plan in a timely manner. However we were told where there were financial and building implications for some actions so these would be addressed when appropriate.

Are services safe?

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Staff told us that there was a legionella policy in place (a bacteria found in the environment which can contaminate water systems in buildings). The practice manager told us the practice were exploring external companies to arrange for a review of the water system and guidance regarding any actions required to further limit the risks associated with legionella.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example pulse oximeters, nebulisers, blood pressure monitors and weight measuring scales.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We looked at records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular daily checks of the building and the environment.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being in the reception and waiting area or medical emergencies. For example: There were emergency processes in place for patients with long-term conditions or on end of life care. Staff were able to clearly describe how they would respond to a patient's deterioration in health whilst waiting to see a clinician. There was a proactive approach to anticipating potential safety risks, including changes in demand, disruption to staffing or facilities, or periodic incidents such as staff illness or severe weather. The practice had plans in place to make sure they could respond to emergencies and major incidents. Plans were reviewed on a regular basis.

Staff told us they felt happy they could raise their concerns with the GPs, practice manager or nurses and were comfortable that these would be listened to and acted on. We saw that staff were supported in their role. Staff described what they would do in urgent and emergency situations.

Emergency medicines and equipment were available to use in the event of an emergency, for example a defibrillator. A defibrillator is an electrical device that provides a shock to the heart when there is a life-threatening arrhythmia present. There was a system in place to ensure emergency medicines were in date and stored correctly.

We saw that staff at the practice had received cardiopulmonary resuscitation (CPR) training. The staff we spoke with confirmed this and training certificates were available.

Staff confirmed if they had daily concerns they would speak with the GPs, the practice manager or the nurses for support and advice. The GPs and nurses discussed risks at patient level daily with the other clinicians in the practice.

There was a good selection of information displayed in the reception area, lobby, in the patient leaflet and practice website regarding urgent medical treatment both during and outside of surgery hours. The practice leaflet was

Are services safe?

available in both English and Polish the two main languages used in the area. Staff told us that translation services were available for patients who did not have English as a first language.

Arrangements to deal with emergencies and major incidents

We saw records which demonstrated that both clinical and non-clinical staff had received training in Basic Life Support within an appropriate time frame. All staff we asked knew the location of the Automated External Defibrillator, oxygen and records we saw confirmed these were checked regularly. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest,

anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included access to the building, power failure, unplanned illness and adverse weather conditions. The document also contained relevant contact details for staff to refer to.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training. Staff told us regular fire drills were undertaken.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GPs and nurses how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Clinical staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

We found that clinical staff had a system in place to receive relevant updates about new guidelines and these were then put into practice to improve outcomes for patients. There were GP leads in specialist clinical areas such as dementia. The nurses supported this work, but led on areas such as diabetic care, hypertension, family planning, childhood immunisations and respiratory care. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Our review of the clinical meeting minutes confirmed that this happened. All GPs and nurses had undertaken minor illness training and were able to provide treatment and care in this area.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with respiratory diseases were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure

multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met. Patients we spoke with on the day told us that they were satisfied with their assessments and felt that their needs were met by the clinicians.

Patients received appropriate advice about the management of their condition including how they could improve the quality of their lives. We saw extensive evidence of comprehensive care planning for patients with long term conditions, patients in care homes and those patients receiving palliative care. Anticipatory care planning reflected patients' wishes relating to hospital admission and end of life care. The practice ensured care plans were accessible to other agencies, such as out of hours services to ensure their full involvement and to facilitate sharing of information. The practice referred patients appropriately to secondary and other community care services.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included for example, data input, clinical review scheduling, and medicines management. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes, hypertension and asthma and the latest prescribing guidance was being used.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from areas of interest to them or the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example,

Are services effective?

(for example, treatment is effective)

the practice had undertaken an annual audit looking at deaths for patients registered at the practice. The aim of the audit was to identify any changing patterns in the place or mode of death and to continue to review whether patients had been able to die in their preferred place. The results of this audit identified a lack of Do Not Attempt Cardio Pulmonary Resuscitation orders in palliative care patients care records. This is a legal order which directs medical teams to the patient's resuscitation preferences. Since this audit the practice had worked to ensure these orders were in place in patient's records and had increased their advanced care planning for all palliative patients. Other audits included cervical cytology audits; these identified where inadequate samples had been taken, any training requirements for individual sample-taking staff, and learning points for future sampling. In addition we looked at audits of intrauterine coil device fittings undertaken annually since 2013. These identified that patients had been appropriately counselled prior to fittings and that the procedures had been undertaken appropriately. We saw that following audit, the outcomes and actions were discussed with the practice team. The practice maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 76% of patients with learning disabilities had received an annual health or medication review.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as hypertension and diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that,

after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had implemented the Gold Standards Framework for managing patients with palliative care needs who were nearing the end of their lives. Patients were signposted to external organisations that could offer support, such as specialist Macmillan nurses. The practice maintained a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. We looked at the minutes of the palliative care and end of life meetings and found that individual cases were being discussed and care and treatment planned in line with patients' circumstances and wishes.

Effective staffing

Practice staffing included clinical, managerial and administrative staff. We viewed training records and found that all staff had received annual basic life support and safeguarding of children and vulnerable adults. Staff had also been trained in the use of the equipment used at the practice. Training of all staff was regularly reviewed. All staff undertook an induction when beginning their role at the practice, we saw this included safeguarding training, health and safety and fire procedures. In addition staff received regular updates during clinical governance meetings which covered potential issues with vulnerable adults and children, the mental capacity act, deprivation of liberty, safeguarding and whistleblowing.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

Staff we spoke with told us they had received regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. In addition the practice was in the process of developing regular quarterly supervisions with all staff. Personnel files we examined confirmed these included reviews of

Are services effective?

(for example, treatment is effective)

performance and the setting of objectives and learning needs. All of the GPs within the practice had undergone training relevant to their lead roles, such as adult and child safeguarding.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, practice nurses provided asthma and chronic obstructive pulmonary disease (COPD) monitoring and administration of childhood and travel vaccines. We saw that the practice nurses and healthcare assistants had been provided with appropriate and relevant training to fulfil their roles.

Reception and administrative staff had undergone training relevant to their role. Staff described feeling well supported to develop further within their roles. We noted a good skill mix among reception, administrative and clinical teams. For example one member of the practice nursing team had begun their working career as a health care assistant and now trained and qualified had returned to the practice as a practice nurse, the practice was a GP and medical student training practice, however due to workload commitments the practice was unable to facilitate trainee GPs and medical students at the time of our inspection. In addition one GP provided clinical supervision and training for the practice nurse whilst on their non-medical prescribing course and prior to them becoming the first nurse practitioner at the practice.

We saw there was a process in place to manage poor performance of staff members.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and support those patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held daily morning clinical breaks which allowed for informal opportunities to discuss care and

treatment and seek advice from colleagues. One GP told us the skills they acquired in other roles, such as one GP had occupational health qualifications had proved advantageous to working age patients. Areas such as palliative care, treatment of patients with dementia and vulnerable adults and children had provided the GPs with experience in assessing capacity and caring for people with cognitive impairment.

The practice held multidisciplinary team (MDT) meetings monthly to discuss patients with complex needs, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. The practice provided medical cover as hospital practitioners to a local rehabilitation unit. We were told the community geriatrician and a representative from the local CCG medicines management team worked with the practice team to provide expertise and advice on effective treatment and prescribing. GPs provided weekly ward rounds to a local care home as well as attending the home for any urgent patient medical needs. The practice also provided medical services to students at a local boarding school including twice weekly visits to the school.

The practice website provided patients with information about the arrangements to share information about them and how to opt out of any information sharing arrangements.

One GP was a qualified trainer for sexual and reproductive healthcare and provided in-house training for nurses and GPs at the practice and for other practices.

The practice provided the use of consulting rooms to a number of other services. These included the learning disability partnership, the mental health trust and monthly neurology clinics provided by the Addenbrookes Hospital neurology department. Midwives provided twice weekly clinics and mental health counsellors' hosted weekly clinics at the practice. The practice referred patients to a drug recovery service. In addition the practice promoted referrals to a younger persons support service. Staff told us the Carers Trust and Carers Network had also provided services from the practice with positive outcomes for patients.

Are services effective?

(for example, treatment is effective)

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

A consent policy was in place that identified the different types of consent that could be obtained including implied, verbal and written. We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). The GPs we spoke with were clear about mental capacity in relation to the assessment of a patient's ability to consent to receiving care and treatment. This included patients with a learning disability or dementia where a judgement was required to

be made on their mental capacity to consent and whether a decision was required to be made in their best interests. We were satisfied that correct procedures were being followed.

Nursing staff were aware of the need to consider whether a person attending with a child had the legal right to agree to consent to treatment on their behalf. This included where child immunisations were due and a child attended with a person that might not be legally entitled to consent to treatment on their behalf, such as a step-relative or grandparent.

The practice also followed the correct procedures when considering making Do Not Attempt Cardio Pulmonary Resuscitation orders. This involved support for patients to make their own decisions and how these should be documented in the medical notes.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). Clinical and reception staff we spoke with told us that if a child under the age of 16 attended for an appointment with a GP or nurse without a parent or guardian and they indicated that they did not want one present, they would be given an appointment. The GPs we spoke with were aware that they then had to apply the Gillick competency test.

All staff we spoke with were familiar with the importance of patient consent. For example a code was added to the computer records of patients with literacy problems to alert staff to their needs, different picture methods of communication were available to aid communication and understanding. In addition the practice was able to offer sign language interpretation for staff when patients who used sign language attended the practice. The practice electronic system contained 'hot keys' to enable staff to document that patients had been asked for consent and offered a chaperone.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

We saw that all new patients were asked to complete a general health questionnaire when they first registered and were asked to make an appointment within six months to see a healthcare assistant (or a GP if repeat medicines were required) for a health check and exploration of their medical history and lifestyle. The practice offered NHS Health Checks to all its patients aged 40 to 75 and these checks were undertaken by the healthcare assistant. The performance of the practice in this area was monitored and data reflected that targets were being achieved.

The computerised record system was used to identify patients who were eligible for healthcare vaccinations and cervical screening. We saw a clear process that was followed for patients who did not attend for cervical smears. Flu and shingles vaccinations were available for elderly patients or those with conditions that made them vulnerable to the virus. The practice achieved 71% uptake for patients eligible for a flu vaccination during the 2014/2015 flu campaign and the practice reported 83.8% of patients had attended for cervical screening within the last five years. Patients could also attend the practice for smoking cessation advice and smokers were identified through the patient record system and pro-actively contacted to attend the practice.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice achieved between a minimum of 83% to a maximum of 100% for the previous years childhood immunisation uptake. These were all above average for practices in the local clinical commissioning group area. We were told the practice had achieved a high uptake of immunisations amongst the traveller families, although a limited presence in the area, we saw the practice worked collaboratively with local health visitors and school nurses to achieve this.

There was a wealth of health promotion information available at the practice. This included information on safeguarding vulnerable patients, requesting a chaperone, victim support and support for patients and their carers on the noticeboards. The practice was aware of the strategic objectives of the health and social care needs of the local area and provided a wide range of information on health topics. For example seasonal information on travel vaccinations, how to avoid heat stroke or sun burn and

what to do in such circumstances and how to keep children safe in hot weather. One practice nurse was the lead for health promotion information and the lobby area also contained a wide range of topical health guidance for patients with diseases such as lupus and diabetes; health advice for patients who were interested in smoking cessation, reducing their alcohol intake and guidance on maintaining a healthy body weight and lifestyle. In addition there was information for pregnant mothers, womens and mens health, patients who had suffered bereavement, sexual health, and contact information for other support organisations such as Age UK. Chlamydia testing kits were available for patients attending the practice. Information was regularly reviewed to ensure it remained current.

The practice website also provided access to a range of contact and self-care information. For example the website contained advice on treatment for common conditions such as colds, nosebleeds, insect bites and sore throats. In addition there was wide range of contact numbers for patients to access including local hospitals, chemists, social services and the Samaritans. The practice website offered a facility to translate information into over 80 languages and a facility to increase font size for those patients with reduced visibility. We saw that the practice leaflet, diabetic information and the Choose Well leaflets were readily available in the reception waiting area in both English and Polish to reflect the most common languages spoken in the area, as was the touch in screen in reception. Staff told us these were also available in large print for patients with reduced visibility.

The practice had a register of patients in need of palliative care, suffering from dementia, those who were frail and at risk of their health deteriorating rapidly and for those with learning disabilities, 98% of patients with a diagnosis of dementia had received a dementia health review. Monthly multidisciplinary meetings took place where the care and treatment of individual patients was discussed. This identified the most appropriate care and treatment for them and allowed them to be treated in their own homes. One GP described how the practice had provided support for patients who lived on the river this included home visits for temporary patients who were holidaying on river boats. Other healthcare professionals involved in this process included practice nurses, district nurses, social services and Macmillan nurses.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We looked at data from the 2015 National Patient Survey, carried out on behalf of the NHS and reported on the NHS Choices web-site. We noted that 76% of patients stated they would recommend the practice with 83% stating that they felt the practice was good or very good; these were among the middle range of ratings nationally. 90% of patients reported that the reception staff were helpful. This was higher than the national average. The survey showed satisfaction rates were also high for patients who thought they were treated with care and concern by the nursing staff (99%) and by the GPs (88%). This was higher than the national average and was confirmed by the comment cards we reviewed, the view of the patients we received during our visit and our observation throughout the day. Of the patients who responded to the most recent Friends and Family test 100% said they would recommend the practice.

We reviewed the four comment cards that had been collected from patients. None of the comment cards indicated any negative or critical opinions and all of the cards reported wholly positive experiences of patients. Some of the cards referred to doctors and staff by name, singling out individual examples of kindness, care and compassion. This was reflected in our conversations with patients during our inspection. Patients said they felt staff were caring, efficient, friendly and professional. They said staff treated them with dignity and respect. All the patients we spoke with told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that there was a chaperone policy in operation and a notice was displayed in reception that invited patients to ask if they required such a facility. A chaperone is a person who might be present during a consultation when an intimate examination is taking place to ensure that

patients' rights to privacy are protected. Nursing and other clinical staff were primarily used as a chaperone. There were designated staff who would act as a chaperone if nursing staff were not available. Staff who undertook chaperoning had received training and spoke knowledgeably about the correct way this should be undertaken. This included where to stand to be able to observe the examination.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. Reception staff explained how patients could request a private room to discuss anything they did not wish to discuss in the waiting area and this would be arranged. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

We found that patients were involved in decisions about their treatment. The National Patient Survey 2015 showed that, on average, 89% of patients felt the GP was good giving them enough time, good at listening to them and 88% were good at explaining test results to them. The survey showed that 78% of patients felt that the GP was good at involving them in decisions about their care. These satisfaction rates were similar to the average for both the local CCG area and for England in general. The corresponding figures for the nursing staff were above the England and CCG average with 98% reporting that the nurses gave them enough time, 97% reporting that the nurses listened to them and 95% explained test results, whilst 87% felt the nurses involved them in care decisions.

Our interviews with patients on the day of our visit showed that patients were very satisfied with their level of

Are services caring?

involvement. Patients said that their diagnoses were explained well by the GPs and nurses and that they had opportunities to ask questions to enable them to make informed decisions.

We found that patients who were referred onwards to hospital or other services were involved in the process. We saw that patients could make a choice about where and when to receive follow-up treatment from hospital providers by the use of the 'choose and book' system.

The practice had access to translating and interpreting services for patients who had limited understanding of English to enable them to fully understand their care and treatment.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received were positive about the emotional support provided by the practice and rated it well in this area. For example, these highlighted that staff across the practice and the dispensary responded compassionately when patients needed help and provided support beyond what was required. The survey information we reviewed was also consistent with this information.

Notices in the patient waiting room and patient website also told patients how to access a number of support

groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

The practice had a system for ensuring that all relevant staff were informed of the death of a patient. This was to reduce the risk of any inappropriate contact by the practice staff following the death, for example issuing a letter in the name of the patient. Patients were supported by the practice when a close relative died. The waiting area included various information which sign posted people to support available including citizen's advice, counselling and bereavement services. A named GP visited patients towards the end of their lives and supported family members alongside the community matron and nursing team. Traumatic events such as a death or loss of a child during pregnancy were identified and support offered including signposting to other services. If the service was unable to meet the patient's needs they could refer the patient to trained counsellors and mental health support. Staff we spoke with said that patients at the end of their life and their family were provided with whatever support they needed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example patients who were taking blood thinning medication and required a regular International Normalized Ratio or INR blood test (a regular blood test to review and monitor the effectiveness of long term blood thinning medication), were able to access evening appointments between 5pm to 6pm for their INR blood test. In addition the practice provided home visits to patients who were unable to attend the practice for their INR test; the practice also provided an INR service at a local supermarket for its patients. The practice manager told us this had proved popular as patients did not have to attend the practice, parking was easier and convenient at the store and patients could readily access the service whilst doing their weekly shopping.

The practice had systems in place to seek and act on feedback from patients. There was a suggestions and comments box available for patient's feedback in the waiting room areas. The practice had an active patient participation group (PPG, this is a group of patients registered with the practice who have an interest in the service provided by the practice.) to help it engage with a cross-section of the practice population and obtain patient views. The practice had appointed a PPG chairperson and secretary. There was evidence of quarterly meetings with the PPG throughout the year. The practice was prepared to implement suggestions for improvements and make changes to the way it delivered services in response to feedback from the PPG. The PPG also facilitated annual open meetings with external speakers attending to inform the public and patients of general wellbeing and to answer any health related questions. We were told the last open

meeting topic was medicines management. The PPG also facilitated an annual patient questionnaire, the results from these surveys were fed back to the practice and an annual action plan was implemented based on the results and recommendations.

Home visits with GPs and nurses were available where patients were unable to attend appointments at the practice. The practice operated a duty doctor system and telephone consultations were available each day. Same day emergency appointments were available. Internet access was available for patients who may need to book appointments and request their prescriptions on-line.

The practice provided care to local care homes and a local boarding school. The practice worked closely with staff and school nurses to ensure continuity of care. GPs visited the homes and school on specific days for any routine issues. However, we were told, should patients need additional medical input during the week, the GP would attend for home visits or patients could attend the practice.

Nurses and GPs contributed to the early detection of conditions through the health assessment and screening checks provided by the practice nurses. Patients we spoke with told us they were advised of their test results promptly and we were told the GPs discussed the results with them if further treatment was required. The practice maintained a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients' and their families' care and support needs. Patients who were carers were offered support through the carer's support group.

Patients were able to request repeat prescriptions by email or to attend the practice personally. Prescriptions would be ready within 72 hours. There was a palliative care register and the practice undertook regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. An audio loop was available for patients who were hard of hearing and staff were aware of the different needs of the patients who attended. For example patients with impaired vision.

There were accessible toilets and baby changing facilities were available. The practice had access to a telephone translation service and sign language translation services. The website was available in over 80 languages and

Are services responsive to people's needs?

(for example, to feedback?)

provided an option for larger font sizes. The practice leaflet and other patient information was available in both English and Polish to reflect the most common languages in the area.

The appointment check-in facility in the practice was set up to reflect the most common languages in the area. Staff had access to an interpretation and translation service. Staff reported that there was little diversity within their patient population. However they were knowledgeable about language issues and described how they would access an interpreter to the benefit of the patient. They also described awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes.

Patients who were homeless were able to use the practice's address to register as a temporary patient.

Equality and diversity training had been provided to staff.

Access to the service

Appointments were available daily from St Mary's Surgery between Monday and Friday: 8.30am – 6.00pm with evening GP appointments available Monday and Wednesday evenings from 6.30pm up to 7.30PM. These were pre-bookable appointments designed to be used by patients going to work or who relied on transport from working family members. Patients could also register to book appointments, request repeat prescriptions and view their patient records online. Due to appointment demand the practice had introduced a triage by telephone service in March 2014. All requests for home visits and urgent/on the day appointments were triaged by a GP or a Nurse. Appointments were then made with a GP or nurse as required. The majority of clinical staff had received minor illness training to facilitate this service.

Priority was given to patients with emergencies and to children. Some appointment times were blocked off for this purpose. They were seen on the same day wherever possible. Patients we spoke with on the day told us that they had been able to get appointments for themselves, their family members or their children when required. Patients could select their GP of choice if they were available. Chaperones were readily available for patients to use on request and the practice offered a text appointment reminder service.

The practice nurses ran separate clinics for people with long term conditions such as diabetes. Nurses also

provided specialised 'inhaler clinics' for patients with a diagnosis of asthma and other respiratory diseases. There were health promotion appointments available at the practice, such as for intrauterine coil insertion or removal. Signs were available in the reception and waiting room area that explained the appointment system. It also explained how to obtain emergency out of hour's advice through the 111 system.

Appointment times were staggered throughout the day in response to patient dynamics. Patients were usually allocated ten minute appointment times with the GPs and the nurses. These were extended when necessary for patients with learning disabilities, long-term conditions, patients suffering from poor mental health or those with complex needs. Patients with learning disabilities were given a double appointment where necessary to ensure all healthcare needs could be adequately discussed.

A system was in place so that older patients and those with long term conditions could receive home visits or telephone consultations. Time was set aside each day to manage these consultations. Patients who were housebound or with limited mobility could receive home visits and these were identified on the patient record system. GPs often provided patients on end of life care personal 24 hour and weekend contact information to ensure continuity of care.

The practice provided access for the local midwife clinic twice a week to provide care and support to patients during pregnancy. The GPs provided 24 hour cover, seven days a week to an inpatient rehabilitation ward at a local hospital and worked closely with a consultant community geriatrician and their team at three local care homes. The practice also provided medical support at a local boarding school.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, their call was diverted automatically to the out of hours service. Information on the out-of-hours service was provided to patients.

Are services responsive to people's needs?

(for example, to feedback?)

Patients were satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

The policy explained how patients could make a complaint and included the timescales for acknowledgement and completion. The process included an apology when

appropriate and whether learning opportunities had been identified. The system included cascading the learning to staff at practice meetings. If a satisfactory outcome could not be achieved, information was provided to patients about other external organisations that could be contacted to escalate any issues.

All staff were aware of the complaints procedure and were provided with a guide that helped them support patients and advise them of the procedures to follow. Complaints forms were readily available at reception and the procedure was published in the practice leaflet and on the practice website.

We looked at 14 complaints received in the last 12 months. We saw that where lessons were learnt and individual complaints had been acted on in a timely manner with learning outcomes cascaded to staff within the practice.

The practice audited both written and verbal complaints. We were told since the introduction of the daily triage system the practice had received positive feedback from patients, particularly those who have managed to sort out their problem with a simple phone call rather than an appointment.

Are services well-led?

Good 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The practice had a clear vision to deliver personal health care of a high quality and to seek continuous improvement on the health status of the practice population. The practice objective was to offer a high standard of care to all of its patients. The practice aimed to provide healthcare on an equal basis to all of its patients, regardless of their background, ethnicity and from a safe location that was fit for purpose. The practice worked with the local community to bring care as close to patients homes as possible. We spoke with patients, reviewed four completed CQC comment cards, the results of the Friends and Family Test and patient surveys. All the information reviewed was aligned to St Mary's Surgery delivering its aims and objectives. Staff we spoke with took an active role in ensuring provision of a high level of service on a daily basis and could provide clear examples of how this had been achieved.

There was a defined structure and each department had a team lead who reported to the practice manager and to the partners on certain clinical issues. Staff spoken with were clearly aware of the direction of the practice and were working towards it. Staff job descriptions and appraisals supported the direction in which the practice wished to head and they were clearly linked to the aims and objectives of the partnership. Staff told us they felt involved in the future of the practice and embraced the principle of providing high quality care and treatment.

The practice leadership team were aware of the importance of forward planning to ensure that the quality of the service they provided could continue to develop. They viewed their involvement in nurse and GP education as an important part of this bringing with it the prospect of encouraging newly qualified clinicians to consider careers in primary care.

The partners were committed to improving primary healthcare and recognised the value of research. The practice used clinical audit to monitor the effectiveness of the care and treatment they provided and were a host practice for NHS primary care research initiatives. The practice provided patients with information about this so that they were aware that they may be contacted to be invited to take part in research projects based at the practice.

Governance arrangements

There was a management team in place to oversee the systems at the practice, ensuring they were consistent and effective. The management team covered all the practices run by the practice. The practice had a number of policies and procedures to govern activity and there were systems in place to monitor and improve quality and identify risk. All the policies were available to staff via the desktop on any computer within the practice. The management team were responsible for making sure policies and procedures were up to date and staff received training appropriate to their role. We saw evidence that feedback from patients was discussed and shared at the weekly staff meetings and learning was applied. The management team also met on a regular basis. For example the practice held six whole practice in house clinical governance meetings per year, these were used to provide mandatory training, update staff on new guidance and information and provide group training for the various teams within the practice.

There was a clear leadership structure and staff felt supported by management. Staff were aware of their roles and responsibilities for managing risk and improving quality. GPs and nurses had lead responsibilities for areas such as safeguarding, infection control and care related to patients with dementia.

We saw the practice had developed a significant event reporting process over ten years ago and held monthly significant event meetings with GPs and team leaders. One GP and the practice manager undertook quarterly reviews, from these reviews they compiled a report of their findings, the learning outcomes of which were fed back and discussed with all staff.

The practice had arrangements for identifying, recording and managing risks. The assistant practice manager showed us the risk log, which addressed a wide range of potential issues, including health and safety and fire risk assessments. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example risks identified from significant events, patients comments and complaints. These were clearly identified and reviewed on a regular basis to ensure that patients and staff were safe.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. This is an annual incentive programme designed to reward good practice. The QOF data for this practice showed it was performing in

Are services well-led?

Good 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

line with local CCG and national standards. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes. Team meetings were used to discuss issues and improve practises. We looked at minutes from the last two team meetings and found that performance, quality and risks had been discussed.

The practice had a programme of clinical and non-clinical audits which it used to monitor quality and systems to identify where action should be taken and drive improvements. These included QOF performance, infection control, mortality rates and prescribing.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and a lead for safeguarding within the practice. Clinical staff also had lead roles in relation to their clinical expertise. There was a lead GP for a number of medical conditions for example diabetes and women's health. The staff we spoke with were aware of their own roles and responsibilities and knew who had lead responsibility in the practice for other areas.

We saw from the minutes we looked at that staff meetings were held regularly. Staff told us that felt valued, well supported and knew who to go to in the practice with any concerns. We were told there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or clinical meetings as appropriate. There was a willingness to improve and learn across all the staff we spoke with. Staff told us they felt the leadership in place at the practice was consistent and fair and generated an atmosphere of team working.

The practice encouraged and valued feedback from patients. It had gathered feedback through the patient participation group (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care), surveys, significant event analysis and complaints received. It had an active PPG founded in 2010. A chairperson and secretary had been appointed. The PPG met quarterly and had coordinated an annual patient survey. We looked at the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website and on the dedicated PPG notice board in the reception waiting area. We spoke with one members of the PPG and they were very

positive about the role they played and told us they felt engaged with the practice. We were told the practice were quick to respond to patient comments. For example one patient had raised concerns about the decoration of one area of the practice and another had reported that antiseptic hand gel was situated at a height not suitable for all patients. We saw the practice had taken prompt action to address these issues. We were told PPG members helped out at annual flu campaigns to act as marshals and liaise with patients.

We also saw evidence that the practice had reviewed its' results and feedback from the national GP survey, Friends and Family Test and NHS Choices to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice. A quarterly practice newsletter was produced giving patients health advice, NHS information and the latest practice news.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. As reported earlier in this report the practice encouraged staff feedback from both internal and external training. Feedback from the training was reviewed by the practice manager and GP. The practice had developed a process of staff supervision by team leaders and senior managers for all staff in the previous 12 months. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us the practice encouraged personal development, and provided training where a need of on-going provision or a new area of need for good practice had been identified. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance. We spoke with a range of staff who confirmed they received annual appraisals where their learning and development needs were identified and planned for. We viewed records that effective appraisal processes were in place that had been maintained over a number of years. Every staff member had a folder which included details of annual appraisal, training and supervision. Team leaders were aware of governance issues relating to their teams.

Are services well-led?

Good 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Clinical staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We saw that dispensary staff and healthcare assistants undertook national vocational qualifications with the support of the practice. As reported earlier in this report one practice nurse received clinical supervision and training from one GP whilst working towards their non-medical prescribing course and nurse practitioner status. In addition to their mandatory training they were supported to attend study days each year to undertake training in areas of their specialist interest. Staff told us the practice were very supportive This enabled clinical staff to meet the revalidation requirements for their professional registration. We reviewed six staff files and saw evidence that appropriate training had been undertaken by staff.

There was a strong focus on clinical excellence and training and support for clinical staff. Care and treatment provision

was based upon relevant national guidance, which was regularly reviewed. The practice had completed reviews of significant events and other incidents and complaints and shared with staff in meetings to ensure the practice improved outcomes for patients. Records showed that regular clinical and non-clinical audits were carried out as part of their quality improvement process to improve the service and patient care. Completed audit cycles showed that essential changes had been made to improve the quality of the service and to ensure that patients received safe care and treatment.

The practice was one of 12 practices to offer newly qualified GPs sessional employment in addition to the Deanery offering subsidised training for 12 to 24 months. The practice was also working towards introducing work based staff apprenticeships for administration and reception roles.